Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: OIG	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: OIG	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of participant directed employees complying with personnel requirements.
N=number of participant directed employees who have completed personnel requirements.
D=total number of participant directed employee records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Each operating agency gathers and reports.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: OIG, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: OIG, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of reviewed providers in which staff have successfully completed mandatory training annually. N= All reviewed providers whose staff have successfully completed mandatory training. D= Total number of reviewed providers

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
Each operating agency gathers and reports.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: OIG	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: OIG	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Providers must meet health, safety, and welfare standards upon initial enrollment into the program. The state currently verifies that 100% of all MPW waiver providers are qualified, certified or licensed prior to rendering services. Providers who have completed new provider training/evaluation or are licensed by OIG are eligible to become Medicaid providers. The State's' Office of Inspector General (OIG) monitors and re-licenses annually. Providers are recertified at least every two years. The state does not contract with non-licensed or non-certified providers. All State policy and procedure updates, additions, and/or changes are communicated through letters and the DMS website.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Department for Medicaid Services provides trainings upon request of providers and provides technical assistance when requested. DMS terminates a provider who does not meet requirements to provide services.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. Michelle P Waiver (MPW) does not include residential settings. MPW participants receive services in a day program setting and/or provider offices. Kentucky is currently in the process of validating settings that will be designated as Category 4, and thus, will undergo heightened scrutiny. Onsite visits to providers preliminarily identified as Category 4 concluded in August 2016. Kentucky will send a validated list of the settings that will require heightened scrutiny to CMS by January 2017.

The providers will be expected to be compliant by March of 2019, as stated in Kentucky's statewide transition plan, with ongoing education to ensure compliance. Provider settings will be monitored during annual reviews utilizing monitoring tools that have been updated to include the federal requirements.

2. Provider settings will be monitored during annual reviews utilizing monitoring tools that have been updated to include the federal requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Participant Directed Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- [ ] **Social Worker**

  Specify qualifications:

- [ ] **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Conflict-free case management shall not include provision of direct services. Agencies providing case management services to a participant may not provide other waiver services to that same person. For recipients who request an exception to this based on lack of qualified case managers in remote areas of the state, DMS will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers.

If an exemption is approved, the case management agency shall document conflict of interest protections, separating case management and service provision functions within the provider entity. Individuals must be provided with a clear and accessible alternative dispute resolution process.

Exemptions for conflict free case management shall be requested upon reassessment or at least annually.
Department waiver program staff conduct provider billing and service reviews to assure that provided services meet regulatory requirements, are provided as identified in the person centered service plan, and are delivered by qualified staff.

All case managers will monitor an individual's services related to health, safety and service issues on an ongoing basis. The primary focus will be health and safety issues but the case manager will also evaluate the appropriateness and adequacy of services.

Issues with services or problems related to health and safety will be documented and forwarded to the provider, case manager and DMS to ensure that all problems are identified and addressed.

The case manager will document the request for special medical equipment, medical supplies and environmental accessibility services, including the acquisition and implementation of the services approved.

Person Centered Service Plan reviews will be conducted through the prior authorization process. On site monitoring and sampling of records will be reviewed at provider site.

Person Centered Service Plan training is provided for waiver providers. Case management training focuses on educating the case managers about identifying the needs of the person and locating appropriate activities that address the needs of each person.

Information gathered from case reviews is used to develop quality improvements focused on system-wide changes, bolstering the provider's approach to reducing medical errors, which emphasizes a culture of learning, person centeredness, and accountability.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Person Centered Service Plan (PCSP) is developed utilizing the MAP 351 assessment tool which includes information about the participant''s support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, medical needs and overall health risks related to disability and aging. Assessments will be conducted annually on the level of care renewal date.

The PCSP shall include all needs identified through the assessment process, as well as identified goals, objectives/interventions and outcomes. The PCSP is developed with the participation of the participant and/or guardian as well as the participant's identified circle of support. All individuals participating in the development of the PCSP must sign the document to indicate their involvement. It is the responsibility of the case manager to provide detailed information to the member regarding available waiver services and providers to meet the identified needs. The member is encouraged to choose from the listing of available waiver providers as well as identified services.

All PCSP's are reviewed and the requested services prior-authorized through the QIO. When PCSP's are submitted to QIO a copy of the completed MAP 351 is included in the packet. The QIO is responsible for review of the assessment, ensuring all identified needs are included and adequately addressed in the PCSP. If, through the prior authorization process, it is determined that identified needs are not addressed in the PCSP, QIO will issue written notification to the case manager requiring additional information as to how these needs will be addressed.

The CM is responsible for the coordination and monitoring all of the participant's services, including non-waiver services. The CM shall conduct monthly face-to-face contacts with the participant to make arrangements for activities which ensure: the desires and needs of individual are determined; the supports and services desired and needed by the participant are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a PCSP approach is provided as the plan is developed; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are maximized based on need; activities are documented; and plans of supports/services are reviewed at such intervals as are indicated during planning.

The PCSP shall be updated at least every twelve (12) months, and as often as necessary to address changes in the participant's needs. Any changes in the participant's needs shall be identified by the CM during the monthly face-to-face contact. All modifications to a PCSP shall be reviewed by QIO. All PCSP requirements shall be contained in the state regulation governing the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Person Centered Service Plan (PCSP) is developed utilizing the assessment tool which provides information about the participant's support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, and medical needs.

The PCSP shall also identify goals, objectives/interventions and outcomes. The PCSP is developed with input from the participant and/or guardian, persons invited by the participant, as well as other service providers. All persons involved in the development of

the PCSP must sign the document to indicate their involvement. It is the responsibility of the CM to provide detailed information to the participant and the person centered team regarding available waiver services and providers to meet the identified needs. The participant is encouraged to choose from the available waiver providers and the identified services.

All PCSP's are reviewed and requested services are prior authorized through the QIO entity contracted by Medicaid through the fiscal agent. When PCSPs are submitted, a summary of the completed assessment is included in the packet. The QIO is responsible for review of the assessment summary ensuring all identified needs are included and adequately addressed in the PCSP. If through the prior authorization process, it is determined that identified needs are not addressed in the PCSP,the QIO will issue written notification to the CM requiring additional information related to how these needs will be addressed.

The CM is responsible for the coordination and monitoring of all the participant's waiver and non-waiver services. The CM shall conduct monthly face-to-face contacts to make arrangements for activities to ensure the desires and needs of the participant are identified, the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are coordinated; activities are documented; and plans of supports/services are reviewed at least annually and at such intervals as are indicated during planning.

The PCSP shall be updated at least every twelve (12) months and as often as necessary to address changes in the member's needs. Any changes in the member's needs shall be identified by the case manager during the monthly face-to-face contact. All PCSP requirements shall be contained in the state regulation and manual governing the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the participant are identified during the Assessment process. All health, safety and welfare risks are required to be identified and addressed in the person-centered planning meeting and on the PCSP.

Training specific to risk assessment and mitigation is provided to the Case managers.

Providers are required to have agency emergency plans and person specific crisis and safety issues incorporated into their person centered service plan. The QIO reviews the submitted assessments through prior authorization process, plan of care review, to ensure all identified risks are appropriately addressed.

If the review determines that an identified risk has not been addressed in the PCSP, the QIO and/or DBHDID will conduct an on-site review and/or issue written notification to the case manager requiring additional information as to how these risks will be addressed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The participant's case manager is responsible for notification of available waiver service providers. Documentation of this notification is required to be maintained within the participant's record and shall contain the participant or guardian''s signed acknowledgement.

The case manager is responsible for assisting the participant in choosing providers for services specified in the PCSP. This assistance may include telephonic or on-site visits with participant and their families, assisting them in accessing the provider listing, answering questions about providers, and informing them of web-based provider profiles. QIO will ensure on an individual basis that persons who choose not to have a conflict free case manager will be free from undue influence regarding choice of providers.

All waiver participants are ensured freedom of choice as defined by the experience of independence, individual initiative, or autonomy in making life choices, both in small everyday matters (what to eat or what to wear), and in large, life-defining matters (where and with whom to live and work);
The service, provider and setting are selected by the individual from among setting options including non-disability specific settings;
The individual must be provided with the choice of where to live with as much independence as possible, and in the most community-integrated environment;

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs and preferences, and available resources.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Upon the case manager''s completion of the Person Centered Service Plan (PCSP) it is the responsibility of the CM to submit the PCSP to the QIO for review and for service prior authorization. A prior authorization shall not be issued without QIO review and approval. Medicaid contracts with the Fiscal Agent (FA), who in turn contracts with the QIO to review and prior authorize all service plans.

DBHDID completes first line monitoring of all certified waiver providers
QIO completes the first line monitoring of the HCB agencies providing MPW services.
DMS completes second line monitoring of 20% of the reviews submitted to DMS from the QIO.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case manager for the person receiving MPW funding is responsible for the coordination and monitoring of all of the person's services, including non-waiver and non-paid supports. If the person chooses to participant- direct services, the case manager is responsible for ensuring the person is enrolled in and educated about the Participant Directed Services option.

Case managers facilitate the development of the Person Centered Service Plan (PCSP) and monitor the delivery of supports to ensure that waiver services are furnished in accordance with the PCSP, meet the needs of the person, and achieve the intended outcomes.

Case managers conduct monthly face-to-face contacts with MPW participants to ensure the desires and needs of the participants are determined, the supports and services desired and needed by the person are identified and implemented, housing and employment

issues are addressed, social networks are developed, appointments and meetings are scheduled, a person-centered approach to planning is provided, informal and community supports are utilized, the quality of the supports and services as well as the health, safety, and welfare of the person are monitored, activities and services are documented, and support strategies are reviewed at such intervals as are indicated during planning. The case manager is responsible for ensuring the waiver participant makes a free and informed choice of providers, services, and resources. It is the responsibility of the case manager to provide detailed information to the person regarding available services and providers, including waiver services, health services, or natural community resources to meet needs identified by the assessment tool.

For participants choosing to participant-direct services, the case manager is responsible for ensuring the effectiveness of the back-up plan.

Case managers are responsible for ensuring services provided meet the participant's needs. If services are not meeting the needs of the waiver person, the case manager is responsible for working with the person's support team to ensure different or additional supports are identified and provided and that a Person Centered Service Plan modification is submitted for prior approval within fourteen (14) days of the effective date that the change occurs. Case managers are required to document findings from their monthly visits and monitoring in a monthly summary note which is maintained by the agency in the person's record. If issues related to health, safety and welfare, services, or satisfaction are noted, the case manager is responsible for prompt follow up toward resolution or remediation. In addition to the on-going monitoring of PCSP implementation that is conducted by the case manager, the following strategies are employed;

All providers of traditional MPW services are required to establish policies concerning the health, safety, and welfare of persons supported by the agency. Additionally,traditional providers of MPW services are required to document progression, regression, or maintenance of outcomes identified in the PCSP. Agencies, policies, and documentation records are reviewed at least annually by DBHDID to ensure compliance with these requirements. If deficiencies are noted, a plan of correction is required.

All Person Centered Plans of Care are submitted to QIO for prior approval. If information is insufficient or the plan is inadequate, notification is provided to the case manager who then has fourteen (14) days to respond in writing with additional information.

A random sample of records of people receiving wavier funding including case management notes are reviewed by DBHDID during certification reviews. Issues identified are either addressed through technical assistance and follow up or by citation requiring a corrective action plan (CAP).

Health, safety, and welfare issues are monitored by DBHDID through a risk management process in which serious and grave incidents are reported directly to and reviewed by DBHDID staff. Additionally, minor incidents are reviewed on-site by DMS staff. Issues identified are addressed through technical assistance and follow up, investigation, and/or citations requiring a plan of correction. For persons who choose to direct their own services, the Case Manager or Support Broker is responsible for ensuring health, safety, and welfare. The Case Manager or Support Broker will communicate with the participant, representative, and the person's team as needed.

All findings regarding the implementation of the POC including health, safety, and welfare, are expected to be addressed by the supporting agency. If citations are issued, the agency is required to submit a plan of correction that addresses both the specific individual issue and the systemic issue that resulted in the citation. Acceptable plans of correction are monitored by DBHDID staff to ensure implementation and effectiveness.

Upon completion of all investigations, findings reports are prepared and sent to the provider. Any indication of fraud or abuse is forwarded to DMS for further review.

All certification reviews will be completed by DBHDID agency staff.

Licensed providers are monitored by DMS and the QIO.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of service plans reviewed with a risk assessment that have appropriate risk mitigation. N=number of plans reviewed with risk assessment that have appropriate risk mitigation D=Number of plans reviewed with risk assessment

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO/Personal narrative/MWMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: QIO, MWMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO, MWMA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of service plans in which services and supports align with assessed needs of what is important to the participant. N= Total number of service plans reviewed that reflect assessed needs and preferences D= Total number of service plans reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: QIO/FM	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO/FM	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of services plans that reflect individual goals and preferences of what is important to the participant. N= Total number of service plans reviewed that reflect individual goals and preferences D= All service plans reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: QIO, MWMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Other** Specify: QIO/MWMA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of service plans reviewed that include a risk assessment. N=Total number of service plans reviewed that include a risk assessment D = All service plans reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Personal narrative, MWMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: QIO, MWMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO/MWMA	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of respondents who said their CM gets them what they need. N=Number of respondents who said their CM gets them what they need. D=Number of respondents.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
MWMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: And as needed in response to concerns/complaints received from participant.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Other** Specify: And as needed in response to concerns/complaints received from participant.

Performance Measure:
Percent of respondent families who are satisfied with the services and supports received. N=All family member who stated that their family member always/almost always gets what he or she needs. D= Number of respondents.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: And as needed due to complaints received from participant, family.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	And as needed due to complaints received from participant, family.

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of service plan development activities that are completed as described in the waiver application for reviewed service plans. N = Total number of waiver applications containing service plan development activities that are completed as described. D = Number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: QIO, MWMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO, MWMA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of service plans indicating appropriate change in service related to documented change in participants needs within the year. N= Total number of service plans indicating appropriate change in service related to documented change in participants needs within the year. D= Total number of person centered plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MWMA/QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: QIO, MWMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO, MWMA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of service plans revised at least annually. N = Number of service plans reviewed which were revised at least annually. D = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: QIO/MWMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO/MWMA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person centered plan. N=the number of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person centered plan D=the number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: FA/QIO/HP	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: FA/QIO/HP	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of participants/guardians who were offered choice between/among services and providers and between waiver services and institutional care. N = Number of participant records with participant/guardian signatures, indicating he/they were given choice of providers. D= Total number of service plans reviewed.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: FA/QIO/MWMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: FA/QIO/MWMA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
If the QIO determines an identified risk noted on the assessment has not been addressed on the PCSP, the QIO will issue written notification to the provider requiring additional information as to how these risks will be addressed.

DBHDID perform an initial certification and an annual recertification of enrolled active MPW providers. Monitoring the PCSP includes ensuring all needs are met by appropriate interventions with specific goals and outcomes.

If services are not appropriate, DBHDID will request in the report that a corrective action plan is required. The enrolled provider submits the corrective action plan with supporting evidence of the implementation and remediation.

A follow-up survey/review will be performed after DBHDID' acceptance of the provider''s corrective action plan to determine whether it has been implemented.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DMS receives a utilization management report from the QIO showing the number of service plans received, the number returned for lack of information, the number of service plans corrected and returned in a timely manner, the number not turned in timely and the responsible provider.DMS is able to request corrective action plans from the QIO if a service plan is approved, but does not meet requirements.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

○ **No**
◉ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
Responsible parties will be QIO and DMS. Databases are maintained within DMS based on data received from QIO and DMS staff reviews.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participant Directed Services include:

The Michelle P waiver (MPW) program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. MPW participants have the opportunity to direct some or all of their non-medical waiver services through the Participant Directed Service delivery. Kentucky's PDS option is based on the principles of Self-Determination and Person Centered thinking. A person-centered system acknowledges the role of families or guardians in planning for children/youth and for adults who need assistance in making informed choices.

The principles and tools of self-determination are useful in assisting participants in creating meaningful, culturally appropriate lives in the communities and developing significant and supportive relationships. These principles are Freedom, Responsibility,

Authority, Support, and Confirmation. Tools include support broker, Financial Management Services (FMS) and individualized budgets which are developed annually, based on assessments and the Person Centered Service Plan (PCSP).

Traditional service delivery methods are available for participants who choose not to direct their services. Support brokers provide assistance for informed decision-making by individuals and their families/representatives about the election of participant direction with information and training on the roles, risks, and responsibilities assumed by those who choose participant direction.

The following entities will provide supports to participants choosing to direct their own services:

Support Broker agencies will be independent of service delivery. Support Brokers will assist with the development of a circle of support, plan development, budget creation and management, and resource development. The Support Broker will provide direct assistance to the participant in brokering community resources and directing services. This can include assistance with inclusion, recruiting employees, and plan development. The participant choosing to self-direct can hire his/her own employees that meet qualifications. If needed, the SB will assist the participant in recruiting alternate or additional employees.

A monthly face-to-face contact is required between the case manager and the member and member's representative (if applicable) to ensure the member's needs are being met in an appropriate manner and monitor health, safety and welfare. Support brokers will meet with members face to face monthly or more often as needed.

Supports that facilitate independence include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living as such as bathing, eating, dressing, personal hygiene, shopping and the use of money; reminding, observing, and/or monitoring of medications; respite; socialization, relationship building, leisure choice and participation in generic community activities.

•

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Each person in the waiver is afforded the choice of traditional, PDS and/or blended services (traditional and PDS). It is the Case Manager or SB's responsibility to offer those choices to each participant when the initial assessment or reassessment is performed. The support borker also informs the participant of the cost, fees associated with PDS, the criminal records check, training for the employee, the record keeping and time sheet that must be signed by the employer to verify that the employee's time, attendance and service performed is recorded correctly.

The Support broker will be required to provide information about participant direction opportunities to the participants at the time of initial Person Centered Service Plan meeting, at least annually thereafter, and at any point of recipient or guardian inquiry. Support brokers will complete the Person Centered Service Plan, and provide detailed information regarding the participant directed opportunities available through the waiver program. The support broker will be responsible for explaining the recipient's responsibilities related to participant directed service.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A non-legal representative may be freely chosen by an adult waiver recipient to direct waiver services. This representative may not be hired as an employee to provide any of the participant-directed waiver services. The Representative shall act in accordance with the needs and preferences of the participant, as documented in the assessment and the person-centered planning process.

The SB will be responsible for monitoring the participant's Person Centered Service Plan(PCSP) and ensuring needed services are being appropriately provided to the recipient. The SB will ensure that services are carried out accordingly and that the participant remains satisfied with services over time.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☑	☑
Goods and Services	☑	☑
Financial Management Services	☑	☑
Environmental and Minor Home Adaptations	☑	☑
Home and Community Services	☑	☑
Support Broker	☑	☑
Community Day Supports	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Area Development Districts and CMHCs

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

15 minute units limited to 8 units and not to exceed $100 per member per month

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**
☑ **Collect and process timesheets of support workers**
☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

All financial management services entities are subject to an annual on-site review by DAIL. This review shall include audits of submitted timesheets and supporting documentation against any payments issued to employees by the FMS. The audit shall identify any deficiencies and require a corrective action plan (CAP) from the FMS.

Participant satisfaction surveys shall be conducted annually (at a minimum) and those survey results will be utilized to address and resolve FMS issues.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

- [x] **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The SB is responsible for educating members regarding PDS opportunities. SBs meet with members to detail the PDS options; develop the new Person Centered Service Plan, to include PDS services; establish the participant's budget allowance; and, assist the member with any other question s/he may have regarding participant direction.

A monthly face-to-face contact is required between the SB and the participant and participant''s representative (if applicable) to ensure the participant''s needs are being met in an appropriate manner and to monitor health, safety and welfare.

- [x] **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	☐
Case Management	☑
Goods and Services	☐
Adult Day Training	☐
Supported Employment	☐
Financial Management Services	☑
Community Living Supports	☐
Environmental and Minor Home Adaptations	☐
Homemaker	☐
Attendant Care	☐
Home and Community Services	☐
Support Broker	☑
Physical Therapy	☐
Speech Therapy	☐
Community Day Supports	☐
Occupational Therapy	☐
Behavioral Supports	☐
Adult Day Health	☐
Personal Care	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A person may voluntarily dis-enroll from the participant directed services opportunities at any time. The SB shall assist the member and/or guardian prior to day of the termination in locating traditional waiver service providers of their choice.

Participant directed services (PDS) are not terminated until the traditional service agency is ready to provide services. To ensure continuity of services within one business day, the SB will coordinate the completion of the required documentation to ensure there is no lapse in service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The SB monitors all services provided for the participant and ensures that the health, safety and welfare of participant is guarded.

Participants may be transitioned to traditional services for the following reasons:

1) Health, Safety and Welfare of the Participant. If the SB feels the participant is in immediate danger, an employee or representative has exhibited abusive, intimidating or threatening behavior or the health, safety and welfare of the participant is at risk, the SB will immediately assist the participant in transferring him to a qualified traditional waiver provider of the participant's choice, and notify the Department of Aging and Independent Living (DAIL) of the transfer. In addition, the SB shall immediately notify appropriate agencies and authorities regarding any suspected abuse, safety or neglect allegations.

2) Safety of Provider. If the PDS participant, employee or representative has exhibited abusive, intimidating or threatening behavior toward provider staff, the SB will work with the consumer or the designated representative to discuss the issue and develop a corrective action plan (CAP). The SB will monitor the progress of the CAP. If the participant is unable or unwilling to resolve the issue, the SB will request DAIL to proceed with involuntary transition from the PDS option. If DMS approved, the participant will be provided by the SB with written information regarding the traditional program and available traditional providers and will assist the participant in obtaining a traditional provider. The participant will be provided written notice of a fair hearing 10 days prior to the transition. If the participant requests an administrative level hearing within 10 days of the termination letter, services will continue under PDS until a decision is rendered. The SB shall document the reason for the transition, actions taken to assist the participant to develop a CAP and the outcomes. If the service provider believes the environment is not safe for employees, the provider may choose to notify the SB of intent to cease services immediately. The SB will notify DAIL and every effort will be made to find another provider either for PDS or traditional. If no willing provider is found, the participant will be provided with notice of a fair hearing. In addition, the SB shall immediately notify appropriate agencies and authorities regarding safety or neglect risks.

3) Failure to Follow Service Plan or Act as an Employer: If monitoring activities reflect the participant's needs are not being met in accordance with the approved service plan and/or the funds in the individualized budget are not being utilized according to program criteria and/or the participant or representative fail to fulfill the duties of their requirements as an employer, the SB will work with the consumer or the designated representative to resolve the issues and develop a CAP. The SB will monitor the progress of the CAP and resulting outcomes. If the participant is unable to resolve the issue, or unable to develop and implement a CAP within sixty (60) days of identification of the issue, the SB will request approval from DAIL to proceed with transition to traditional services from the PDS option. If approved, the SB will provide the participant with written information regarding the traditional program and available providers. The SB shall document the reason for the PDS option withdrawal, actions taken to assist the participant to develop a corrective action plan and the outcomes. The SB shall assist the participant and/or guardian in locating traditional waiver service providers of choice. The SB will continue working with the participant and/or guardian and current employees until a traditional provider is located and services are started. The participant will be provided with a fair hearing notice 10 days prior to transition. Services will continue until a decision is rendered. If the participant has been terminated from a traditional service provider due to any of the above listed behaviors, the participant shall not be approved to be served under the participant directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		7100

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 2		7455
Year 3		7828
Year 4		8219
Year 5		8630

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The participant, as the employer, is responsible for the cost of obtaining criminal background checks. If needed, the SB will assist the participant to identify family members, churches or other civic groups and organizations that may be available to provide financial assistance.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

QIO shall establish an individualized, flexible budget annually, based on needs as identified in the assessment and the Person-Centered plan of care. The budget is adjusted as participant needs change. The participant may negotiate wage rates with employees, however the hourly rate shall not exceed the rate reimbursed to traditional waiver providers for a similar service.

The methodology for establishing the budget is included in the program regulation, which is subject to public comment when promulgated or amended and is always available for public review.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The conflict free support broker, with the participant and the team, will work together to develop the person centered service plan and the total budget amount.

At any time, if a participant's needs change, the participant/representative may request the SB to submit a request to modify the service plan. The budget is based strictly on the approved services based on the needs as identified in the assessment. Any increase in services which will impact the budget must be based on changes in the participant's circumstances. If a change has occurred, the SB will request a new assessment from the CMHC. Once a new assessment has been completed the SB will set up a person centered team meeting to create a new service plan. The plan will be submitted to the QIO for approval and, if approved, the changes in services/budget will become effective. In cases of an emergency,

such as coming home from the hospital, the SB can submit a modification for approval by the assessor and QIO without a new assessment. A person centered team meeting to review the modified plan must be scheduled within 30 days of approval of the emergency modification.

If a request for service modification is denied, the participant will be provided with information regarding the fair hearing process. The fair hearing information will be included in the denial letter.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The conflict free support broker and the QIO monitor service usage and budget for each participant. The Department for Aging and Independent Living (DAIL) conducts monitoring reviews of all participants who direct their services and are in contact with DMS and the SB as issues arise.

The PDS budget is based on service units and is monitored for usage by the SB for each participant. The CM provides the participant with monthly budget reports. DAIL conducts random monitoring reviews of participants who direct their services and are in contact with the SB agency as issues arise. CAPs are created in instances where the participant fails to adhere to the service plan by over/under use of service units.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals who are denied level of care, budget adjustment, suspension, reduction or termination of services are issued written notification of appeal rights at the time of denial.

These rights are contained as a part of the denial notices. All appeal rights are outlined in 907 KAR 1:563, “Medicaid Covered Services Hearings and Appeals” which requires written notification of appeal rights to the member and the continuation of waiver services if the appeal is requested within ten (10) calendar days of the date of the notification. The notices are generated electronically at the time of denial.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DMS provides for a reconsideration process that is operated by the QIO. The provider, recipient or guardian acting on behalf of the recipient, may file a reconsideration request upon receipt of written notice of a denial of services or level of care. A written request for reconsideration must be postmarked or submitted to the QIO via facsimile within ten (10) calendar days from the date of the written notice of denial. If the request is postmarked or dated and time stamped by the facsimile service more than ten (10) calendar days from the date of the denial, the request is invalid. A denial may be overturned, upheld, or modified as a result of reconsideration. If the denial is not overturned or if the request for reconsideration is past the ten (10) day time frame, the recipient can appeal the denial through the Medicaid appeal process and request an Administrative Hearing. The process is as follows:

1. The provider, recipient, or guardian acting on behalf of the recipient may file a reconsideration request up on receipt of written notice of a denial of services or level of care.

2. A written request for reconsideration must be postmarked or submitted to the QIO via facsimile within ten (10) calendar days from the date of the written notice of denial. If the request is postmarked or dated and time-stamped by the facsimile service more than ten (10) calendar days from the date of the denial, the request is invalid. As a result, an out of time frame letter will be generated that indicates that the request for reconsideration was untimely and not valid.

3. The QIO will conduct the reconsideration and render a determination within three (3) calendar days of the request.

4. Within two (2) business days of the reconsideration determination, a letter communicating the decision will be mailed to the recipient (or his/her guardian), attending physician, and provider.

A denial may be overturned, upheld, or modified as a result of a reconsideration.

- If the reconsideration determination upholds the original decision to deny service(s) or level of care, the recipient, his/her legal guardian, or his/her representative (authorized in writing) may request an administrative hearing. Administrative hearings are handled by the Hearing and Appeals Branch of the Cabinet for Health and Family Services. For individuals who have a certified level of care and who are receiving services, DMS will pay for continuation of those services through the date a final decision is made, provided that the hearing request is submitted within the specified time frame.

- If the reconsideration determination overturns the original decision, a prior authorization will be issued.

- If the reconsideration determination modifies a portion of the original decision, the portion of the decision that remains denied may be further disputed by the recipient, his/her legal guardian, or his/her representative (authorized in writing) through an administrative hearing. For the portion of the decision that overturns the original decision, a prior authorization will be issued.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The grievance/complaint system shall be operated by the Department for Behavioral Health, Developmental and Intellectual Disabilities for certified providers and the Office of the Inspector General (OIG) for Home Health Agencies and Adult Day Health Care Centers.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver participants may register any grievance/complaint regarding a waiver service provision or service providers through multiple avenues including phone, e-mail, written material via DBHDID.

One resource is the Ombudsman's office, which serves as an advocate for citizens and works to ensure those seeking various services are treated fairly. The Office of the Ombudsman answers questions about DMS programs, investigates customer complaints and works with DMS management to resolve them, advises DMS management about patterns of complaints and recommends corrective action when appropriate.

The participant may contact DBHDID who then will notify the provider of the grievance/complaint. The agency will immediately assess the gravity of the grievance/complaint. If a participant's health, safety or welfare are in jeopardy, the agency will immediately respond. All grievance/complaints are reviewed by DBHDID to identify if additional provider trainings should be developed and conducted.

Additionally, each waiver provider shall implement procedures to address member complaints and grievances. The providers are required to educate all members regarding this procedure and provide adequate resolution in a timely manner. The provider grievance and appeals are monitored through on-site surveys, investigations and technical assistance visits.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The current system has critical incident reporting process. This process is now undergoing changes from three (3)classifications, to only two (2) types of incidents. All individuals/entities providing services shall submit notification of the incident by fax, to DBHDID.

The person discovering the event will determine if the event is critical or non-critical based on the following:

Non-Critical Incident: Any occurrence that impacts the health, safety, welfare, or lifestyle choices of an individual. Incidents are minor injuries, medication errors without any serious outcomes, behaviors or types of situations that do not meet the definition of a Critical Incident.

a. Person discovering the incident must take immediate action to ensure the health, safety, and welfare of the at-risk individual;
b. Reported to the individual's Case Manager (CM), and guardian within twenty-four (24) hours of the discovery of the incident.
c. Recorded by the discovery agency staff on an incident report form.
d. Maintained on prescribed form in the record at the provider site.

Critical Incidents: An alleged, suspected, or actual occurrence of an incident that can reasonably be expected to result in harm to the individual, such as abuse, neglect, and exploitation as defined by KRS Chapter 209: "

"Abuse" means the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury;

"Neglect" means a situation in which an adult is unable to perform or obtain for himself or herself the goods or services that are necessary to maintain his or her health or welfare, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult;

"Exploitation" means obtaining or using another person's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the person of those resources;

Critical Incidents also include, but are not limited to:
-Death
-Homicidal/Suicidal Ideation
-Missing person: An incident not considered neglect and the individual cannot be located for a period of time longer than specified in the person centered plan and the individual cannot be located after actions specified are taken; or circumstances indicate that the individual may be in immediate jeopardy; or law enforcement has been called to assist in the search for the individual.
-Loss of limb

Follow-up action:
a. Person discovering the incident must take immediate action to ensure the health, safety, and welfare of the at-risk individual;
b. Recorded by the discovery agency staff on an incident report form, and reported:
-Immediately to Department for Community Based Services (DCBS), Adult Protective Services (APS) ;
-Within eight hours to the case manager, Department for Medicaid Services (DMS) and guardian by person discovering the critical incident.
d. Maintained on prescribed form in the record at the provider site.

The incident report must include:
i. Identifying Information.
ii. Details of the Incident.
iii. Relevant Consumer Information including, but not limited to Axis diagnoses, recent medical concerns and analysis of causal factors

Licensed Home Health Agencies shall follow Incident reporting requirements according to 902 KAR 20:081 and incident reports are kept on file at the HHA and checked by OIG, DMS, and the QIO during on site visits.
Licensed Adult Day Health Care providers shall follow incident reporting requirements according to 902 KAR 20:066 and incident reports are kept on file at the ADHC and checked by OIG and DMS or the QIO.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DMS provides technical assistance for providers regarding the statutory and regulatory reporting requirements and identification and prevention of abuse, neglect and exploitation. Michelle P providers are required to educate all participants at least annually and more often as needed, regarding recognition of abuse, neglect, and exploitation and the process to report same.

Training is tailored to each individual's learning style and can be provided in a variety of formats. For participants who choose to direct their own services, it is the responsibility of the Case Manager (CM) or support broker to ensure that the participant and all employees are trained on abuse, neglect and exploitation and reporting requirements. Each provider is required to assist and support the consumer''s ability to communicate freely with family members, guardians, friends, and SB/CM.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Critical events/incidents are received by DBHDID staff and reviewed to assess risk to immediate health, safety or welfare concerns. DMS staff consult with the provider/reporter, making sure that steps have been put into place to ensure participant health, safety and welfare.

Critical incidents are reviewed by the Case Manager/SB on a monthly basis to determine appropriate remediation occurred. Reviewed by agency staff on a quarterly basis to analyze data on trends or patterns, agency performance and remediation as documented in the agencies quality improvement plan.

Reports not involving immediate health, safety, or welfare concerns are entered into the DMS database to provide relevance for future provider/participant incidents. If the issue cannot be effectively addressed through standard follow-up procedures, an investigation is initiated by DBHDID.

Investigations may be conducted as desk level or on-site; depending on the nature of the complaint or incident. If the investigation report results in documentation of regulatory non-compliance, the provider is notified by DDBHDID of the findings. Additionally, the Office of Inspector General will be notified, including recommendation for citation(s).

For individuals who choose to direct any or all of their services, the same reporting requirements are required.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DBHDID oversees the reporting of and response of critical incidents that affect waiver participants. A Memorandum of Agreement between the Department for Medicaid Services (DMS) and the Department for Community Based Services (DCBS) includes reporting and conducting collaborative investigations when incidents of abuse, neglect or exploitation occur when participants are enrolled in the MPW waiver.

Upon receipt of a critical incident notifications and/or final reports, each incident is immediately screened by DMS to determine that the provider agency has taken appropriate steps to ensure the health, safety and welfare of the individual(s) involved. DMS addressed any concerns identified appropriately.

Following the health, safety and welfare screening, all incident reports are screened for the appropriateness of provider analysis and reaction. When questions arise that make effective evaluation of the provider's activities impossible, provider staff members are contacted for immediate clarification.

All complaints received are followed up by appropriate DBHDID staff members. Non-critical incidents are monitored through random samples by DBHDID during on site reviews.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

DMS recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of crisis prevention.

DMS is dedicated to fostering a restraint-free environment in all waiver programs. The use of mechanical restraints, seclusion, manual restraints including any manner of Prone (breast-bone down) or Supine (spine down) restraint is expressly prohibited.

The use of chemical restraint is expressly prohibited. A chemical restraint is the use of a medication either over the counter or prescribed, to temporarily control behavior, restrict movement or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into a Person Centered Services Plan and the participants crisis prevention plan as indicated.

DBHDID is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process will reveal trends, patterns and remediation necessary to ensure proper implementation of plan of care and participant safety.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations,

and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DMS recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of crisis prevention.

DMS is dedicated to fostering a restraint-free environment in all waiver programs. The use of mechanical restraints, seclusion, manual restraints including any manner of Prone (breast-bone down) or Supine (spine down) restraint is expressly prohibited.

The use of chemical restraint is expressly prohibited. A chemical restraint is the use of a medication either over the counter or prescribed, to temporarily control behavior, restrict movement or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into a Person Centered Services Plan and the participants crisis prevention plan as indicated.

DBHDID is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process will reveal trends, patterns and remediation necessary to ensure proper implementation of plan of care and participant safety.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DMS recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of crisis prevention.

DMS is dedicated to fostering a restraint-free environment in all waiver programs. The use of mechanical restraints, seclusion, manual restraints including any manner of Prone (breast-bone down) or Supine (spine down) restraint is expressly prohibited.

The use of chemical restraint is expressly prohibited. A chemical restraint is the use of a medication either over the counter or prescribed, to temporarily control behavior, restrict movement or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into a Person Centered Services Plan and the participants crisis prevention plan as indicated.

DBHDID is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process will reveal trends, patterns and remediation necessary to ensure proper implementation of plan of care and participant safety.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency. is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints; and conducting investigations as necessary. The continuous quality improvement process will reveal trends, patterns and remediation necessary to ensure proper implementation of plan of care and participant health, safety and welfare.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

See Appendix G-2a for additional information.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ( ) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percentage of deaths that were expected or medically explained. N = Number of deaths reviewed which were determined to be expected or medically explained. D = Total number of deaths reviewed.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Operating agency's database/MWMA/QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

Operating agency's database/MWMA/QIO		
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Operating agency's database/MWMA/QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of critical incident reports of potential abuse, neglect and/or exploitation submitted within the required timeframe. N= Number of critical incident reports of potential abuse/neglect/exploitation submitted within the required timeframes. D= Total number of critical incident reports of potential abuse/neglect/exploitation submitted.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Operating agency's database/MWMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Operating agency's database/MWMA/QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Operating agency's database/MWMA/QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of incidents in which staff training needs were identified. N = Number of incidents reviewed in which staff training needs were identified. D = Number of incidents reviewed.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Operating agency's database/MWMA/QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☑ **Other** Specify: Operating agency's database/MWMA/QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Operating agency's database/MWMA/QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of incidents in which needed changes were identified. N = Number of Critical/Class 3 incidents in which needed changes were identified. D = Number of Critical/Class 3 incidents reviewed.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Operating agency's database/MWMA/QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: Operating agency's database/MWMA/QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Operating agency's database/MWMA/QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of critical incidents in which providers followed up within the required timeframe. N= Number of critical incidents in which providers followed up within the required timeframe. D= Total number of critical incident reports.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MWMA, QIO, submitted incident reports	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO, submitted incident reports	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of respondents who indicated they can report when something bad happens. N= number of respondents who indicated they know they can report when something bad happens. D = Number of respondents.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
MWMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of respondents who indicated they know how to report when something bad happens. N= Number of respondents who indicated they know how to report when something bad happens. D = Number of respondents.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
Operating agency databases.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MWMA, Operating agency databases, QIO.	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO, Operating agency databases.	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of critical incident reports which indicated the inappropriate use of seclusion or restraints. N = Number of critical incident reports which indicated the inappropriate use of seclusion or restraints. D = Total number of critical incident reports for alleged or reported inappropriate use of seclusion or restraints.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Operating agency databases, MWMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other**	☑ **Annually**	☐ **Stratified**

Specify: Operating agency databases, MWMA, QIO		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Operating agency databases, MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participants with no restrictive interventions including restraints and seclusions reported. N= Number of participants with no restrictive interventions including restraints and seclusions reported. D= Number of participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Operating agency databases, MWMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Operating agency databases, MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Operating agency databases, MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of reviewed participants who had a physical exam in the prior year. N = Number of reviewed participants who had physical exam in prior year. D = Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MWMA, QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of reviewed participants who had a dental visit in prior year. N = Number of reviewed participants who had a dental visit in prior year. D = Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MWMA, QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of reviewed participants who had a health risk screening in the prior year. N = Number of participant reviewed who had a health risk screening in prior year. D = Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MWMA, QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

MWMA, QIO		
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of charts reviewed indicating participants who had a health screening that indicated a need for follow-up had the follow-up. N = Number of charts reviewed that indicated a participant had a follow-up from a health screening that indicated a need for follow-up. D = Total number of charts reviewed of participant who had health screening indicating a follow-up was needed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MWMA, QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Provider agencies are licensed annually by OIG or certified by DMS at least every two years, which includes reviewing employee records for criminal checks and abuse registry checks.
DMS performs monitoring, identifying deficiencies of the MPW waiver provider and requiring a corrective action plan to address the deficiencies identified. During the recertification process, policy and procedures for training provider staff are reviewed and review of incident reports for the period of the review are completed to ensure health, safety and welfare.
DMS monitors the complaint process by reviewing complaints received and providing appropriate follow-up.
By analyzing the trends from incident database on abuse, neglect, exploitation, and injuries reported due to restraint, DMS will monitor agency reporting and remediation of critical incidents both on an individual and agency levels.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DMS AND DBHDID perform monitoring and certification/recertification of the MPW providers.
DMS will terminate provider enrollment should a provider fail to meet provider requirements.
DMS performs monitoring and audit reviews. Recoupment of funds is required when documentation is not present or does not support the services provided as required.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
QIO	
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality

Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DMS strives to actively involve more families, advocates and participants to identify needs, recommend potential solutions to needs, and help in prioritizing needs during the coming years.
DMS is committed to following through on these goals including ensuring that participants receiving support are safe, healthy and respected in their community; living in the community with effective, individualized assistance; and enjoying living and working in their community. Additionally, the House Bill 144 Committee, which includes Legislators, self-advocates, family members, professionals and providers, plays an important role in the short and long-term goals for DMS, including quality of service delivery and best practices.

DMS recognizes the importance of developing comprehensive, systemic, strategic initiatives which outline collection and analysis of data, methods of prioritizing goals, and methods to evaluate effectiveness of implemented strategies.
DMS also realizes that quality improvement for the program must guide each aspect necessary to respectfully and safely support an individual in an effective and efficient manner. It is important for relevant data to be accessible, meaningful and applicable to meet this goal and to ensure safeguards for participants. DMS will monitor incidents; implementation and monitoring of person centered plans; satisfaction of the individual and his/her circle of support; and delivery of timely, appropriate, effective and fiscally responsible supports.
The utilized data will include: LOC determinations; prior authorization, service and expenditure reports; individual plans and outcomes; incidents; monitoring visits; progress toward achieving corrective action plan goals; and recertification reviews. The information will be used to assist providers in developing and acting on their own quality improvement initiatives while integrating expected and best practices.

DMS shall establish a CQI Committee consisting of management staff and those assigned the duties of monitoring implementation and progress of the CQI Plan. The CQI committee shall meet quarterly to review trended data related to the individual, the provider and corrective action plans. This information will be utilized to provide feed back to providers so that actions steps are developed and implemented. The CQI Committee shall review the aforementioned data sets and outcomes on a statewide level to include data from each region as well as data from: assurance measures, remediation, and findings and recommendations related to mortality reviews. Reports of the CQI Committee''s actions shall be presented to an advisory stakeholder committee established through legislative action, the House Bill 144 Commission (HB 144).

PROCESS FOR TRENDING: DMS staff shall assist each provider in aggregation and analysis of data from all incidents, expenditure/service reports, prior authorization of services, monitoring and implementation of person centered plans and level of care evaluations at least quarterly but as often as needed to identify trends and generate action steps to manage identified issues. Quarterly reports will include identified trends and progress on corrective action plans audited by random sample. Findings and recommendations will be made available for review by stakeholders through existing venues such as the Department web site, HB 144 Committee, and sub-committee meetings.

PRIORITIZING: Based upon information gathered from provider certification data, stakeholder input and review of provider communications and incident reports, DMS is setting the following priorities with the implementation of the revised waiver: 1) Person Centered Plans are based upon an individual's assessed preferences and needs. The plans reflect both what is important for and important to the individual; 2) Case managers and direct support professionals complete training and demonstrate skills necessary to assist an individual in attaining what is important to and for them; 3) individuals feel safe and secure in their own homes and neighborhoods and 4) Supports are delivered in a fiscally responsible and effective manner.
DMS believes the data related to achieving these priorities are essential to using person centered thinking to achieve a person centered system that offers individualized supports fashion. Noted trends from the various data sets will be instrumental in establishing best practices and future priorities.

IMPLEMENTATION OF SYSTEM IMPROVEMENTS
Quality Improvement strategies will be implemented at various levels as guided by data trends to include individual level; provider level; regional level; over more than one region when indicated; and statewide. Progress toward achieving outcomes shall be monitored at these levels as well with data flowing through CQI cycle. Any training needed to assist with strategy implementation may be held face-to-face, videoconferencing or online learning modules.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: QIO, MWMA	☑ **Other** Specify: as needed

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Electronic System Design Changes: The Commonwealth has implemented an electronic Medicaid Waiver Management Application (MWMA) to streamline processes across waivers. It will be used by all the Kentucky waivers: KY0.144, KY.0314, KY0.333, KY.0475, KY.0477, and KY.40146.

MWMA will provide automated capabilities around the intake, assessment, eligibility determination, plan of care, case management, incident management, timesheet, and reporting functions performed by waiver service providers. MWMA will eventually integrate with kynect, Kentucky's healthcare connection, providing individuals and families with self-service access to manage their waiver program applications, service plans and services. Information about the system can be found at: http://chfs.ky.gov/dms/mwma.htm#what

Commonwealth staff across all waivers as well as technology staff will be involved in suggesting and designing any applicable system changes. During the first two weeks of implementation of the system there were twice daily status updates to keep abreast of any issues with implementation of the system as well as statistics of individuals being on-boarded into the system.

System of Practice Design Changes: The Commonwealth is in the process of working toward compliance with the final rule. Three areas where considerable strides have been made over the past couple of years have been toward compliance with conflict-free case management, service plans reflecting what is important to and important for each person, and the planning process including both risk assessment and risk mitigation. The targeted standards for improvement are person-centered planning and setting requirements. Commonwealth staff across all waivers is involved in these efforts.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy shall be reviewed for progress and needed revisions at least annually by the DMS Quality Improvement committee with updates and recommendations provided to the DMS MPW Management team. The focus of these reviews shall be utility of quality initiatives; validity of data; determination of best course of action; alterations needed; and information gained. This information will be communicated to all quality improvement stakeholders so that cycle continues.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department for Medicaid Services (DMS) shall conduct annual utilization audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. DMS shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved Person Centered Service Plans (PCSP) shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved PCSP,

DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations.

DAIL shall conduct annual audits of the financial management service entities. These audits shall include a post-payment review of Medicaid reimbursement to the financial management agency for payment to participant's' employees through participant directed services. Auditing will be conducted through random sample of all participant directed records. DAIL shall utilize reports generated from MMIS reflecting each service billed for each participant by financial management agency. Comparison of payments to participant records, documentation and approved PCSP's shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with the approved PCSP, DAIL will initiate recoupment of the monies. Additional billing reviews shall be conducted based on issues identified during these post payment audits.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of claims coded and paid in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. N = Number of claims coded and paid for in accordance with reimbursement methodology specified in the approved waiver and only for services rendered. D = Number of claims coded and paid for.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MMIS, MWMA, QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

MMIS, MWMA, QIO		
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MMIS, MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
--Percent of system defects identified and corrected in the waiver program. N = Number of system defects identified and corrected in the waiver program. D = Number of system defects identified in the waiver program.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
MMIS, MWMA, QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MMIS, MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MMIS, MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
--Percent of rates that remain consistent with the approved methodology throughout the five year waiver cycle. N = Number of rates that remain consistent with the approved methodology throughout the five year waiver cycle. D = Number of rates that fail to remain consistent with the approved methodology throughout the five year waiver cycle.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
MMIS claims, MWMA, QIO

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: MMIS claims, MWMA, QIO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MMIS claims, MWMA, QIO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMS provides technical assistance to providers on an ongoing basis. Providers found to be out of compliance submit and are held to a corrective action plan (CAP). DMS provides trainings upon request of providers and provides technical assistance whenever requested.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other**	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: MMIS, MWMA, QIO	
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

DMS reviews historical usage and expenditures to develop the proposed rate structure. All rates must be approved by DMS and are incorporated into Medicaid state regulations, which are subject to public comment when promulgated or amended.
Paid claim data was reviewed for waiver participants for October 2010 through March 2011 which included total units paid per service, total unduplicated users, total cost, and average units of service and average cost. Data was trended forwarded using historical information, factoring in rate of growth. For new services, rates were established based on rates paid for other services that require similar education and experience.

Rates are established in program regulations. All ordinary administrative regulations are subject to a public comment process during promulgation.

An independent cost study will be conducted during the third waiver year to review the appropriateness of the rates.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services shall flow directly from the waiver providers to the Commonwealth's MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All waiver providers shall be enrolled with the Department for Medicaid Services (DMS), provider enrollment and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to prevent non-enrolled provider claims from processing. DMS or its designee shall conduct annual audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. DMS shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved Person Centered Service Plan (PCSP) shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved PCSP, DMS shall initiate recoupment of the monies.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system (s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ( ) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- (●) **The following source(s) are used**

Check each that applies:

- [x] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Four entities in Kentucky pay health-care related taxes: hospitals, nursing facilities, home health agencies, and service providers for individuals with intellectual disabilities. These are broad-based taxes which apply to all Medicaid and non-Medicaid providers within the specified groups.

Through the biennium budget process, the Kentucky General Assembly allocates funds generated through these health-care related taxes to the Department for Medicaid Services as one funding source which contributes to the overall Medicaid budget. Health-care related tax receipts are not designated to be used for a particular program or purpose within the Medicaid budget.

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	38135.33	8471.88	46607.21	342997.95	6335.86	349333.81	302726.60
2	34521.61	8887.00	43408.61	359804.82	6646.31	366451.13	323042.52
3	34521.61	9322.46	43844.07	377435.29	6971.98	384407.27	340563.20
4	34521.61	9779.26	44300.87	395929.62	7313.61	403243.23	358942.36
5	36218.75	10258.45	46477.20	415330.17	7671.98	423002.15	376524.95

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	10500		10500
Year 2	10500		10500
Year 3	10500		10500
Year 4	10500		10500
Year 5	10500		10500

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay was figured by using the previous waiver years 1-4 from the most current 372(S) reports, which indicated a trend that will max out at 365 days per year for the current waiver at year 5; therefore, this renewal will use an ALOS of 365 for years 1, 2, 3, 5 and 366 for year 4, because of leap year in 2020.
Data referenced above:
9/1/2011 – 8/31/2012 Year 1 - Reported on 372(S) ALOS was 312
9/1/2012 – 8/31/2013 Year 2 - Reported on 372(S) ALOS was 319
9/1/2013 – 8/31/2014 Year 3 - Reported on 372(S) ALOS was 349
9/1/2014 – 8/31/2015 Year 4 - Reported on 372(S) ALOS was 351
9/1/2015 – 8/31/2016 Year 5 – Forecasted based on previous 4 years data, ALOS will be 360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

From the most recent 372(s) report dated 09/01/2014 – 08/31/2015 (Waiver Year 4), the number of units per service reported has been increased by 4.9% to project year 5 of the current waiver (KY.0475.R01.01). The average units per user were also increased by 4.9%. The forecasted increases were calculated using data from the NHE Fact Sheet, for 2014-24, which indicates health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita basis). https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html. The projected units and users for years 1-5 of the renewal will remain flat as it is expected that the waiver will be at capacity in Year 1 and is expected to remain at capacity throughout the renewal period. Because there is not a proposed increase in reimbursement for waiver services, the average cost per unit remains the same as the previous waiver. The reimbursement methodology, including units and unit costs, has been derived from the regulation: 907 KAR 1:835. Michelle P. waiver services and reimbursement (eff. 6-3-2016) http://www.lrc.state.ky.us/kar/907/001/835.htm.
The component cost was derived by multiplying the number of users by the average number of units per user, and multiply that product by the average cost per unit. By summing the component costs and dividing by the number of unduplicated waiver members to be served, the Factor D is derived. There is not a noticeable decrease in Factor D with the removal of therapies; however therapies combined only accounted for .34% (that's .34 of 1%) or $979,993.46 of $291,035,191.99 (Waiver Year 4 - KY.0475.R01.01). Therapies are now available in the Medicaid State Plan.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was determined by trending forward the CMS 372(s) report dated 09/01/2014 – 08/31/2015 (Waiver Year 4) with an annual trend factor of 4.9%. The forecasted increases were calculated using data from the NHE Fact Sheet, for 2014-24, which indicates health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita basis). https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

• Medicare assumed coverage responsibility for the majority of prescription drugs for individuals who are dually eligible for Medicare and Medicaid effective January 1, 2006,
• Kentucky Medicaid stopped paying for the related pharmacy for dual eligibles at the same time.
• Therefore, since 2006, Kentucky Medicaid claims data, which is the basis for the financial estimates included in Appendix J of this waiver application, does not include the cost of prescribed drugs available to dual eligibles under Medicare Part D.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was determined by trending forward the CMS 372(s) report dated 09/01/2014 – 08/31/2015 (Waiver Year 4) with an annual trend factor of 4.9%. The forecasted increases were calculated using data from the NHE Fact Sheet, for 2014-24, which indicates health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita basis). https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was determined by trending forward the CMS 372(s) report dated 09/01/2014 – 08/31/2015 (Waiver Year 4) with an annual trend factor of 4.9%. The forecasted increases were calculated using data from the NHE Fact Sheet, for 2014-24, which indicates health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita basis). https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Health	
Adult Day Training	
Case Management	
Community Living Supports	
Homemaker	
Personal Care	
Respite	
Supported Employment	
Occupational Therapy	
Physical Therapy	
Speech Therapy	
Community Day Supports	
Financial Management Services	
Goods and Services	
Home and Community Services	
Support Broker	
Attendant Care	
Behavioral Supports	
Environmental and Minor Home Adaptations	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**2727615.00**
Adult Day Health	15 Minutes	271	3660.00	2.75	**2727615.00**	
Adult Day Training Total:						**19115068.50**
Adult Day Training	15 Minutes	1926	3609.00	2.75	**19115068.50**	
Case Management Total:						**19602000.00**
Case Management	Monthly	5500	11.00	324.00	**19602000.00**	
Community Living Supports Total:						**22060390.80**
Community Living Supports	15 Minutes	1995	1996.00	5.54	**22060390.80**	
Homemaker Total:						**329829.50**
Homemaker	15 Minutes	77	659.00	6.50	**329829.50**	
Personal Care Total:						**201280863.60**
Personal Care	15 Minutes	7785	6337.00	4.08	**201280863.60**	
Respite Total:						**9940875.00**
Respite	15 Minutes	5250	541.00	3.50	**9940875.00**	
Supported Employment Total:						**321120.56**
Supported Employment	15 Minutes	337	172.00	5.54	**321120.56**	
Occupational Therapy Total:						**487832.40**
Occupational Therapy	encounter	127	99.00	22.17	**278743.41**	
Occupational Therapy Assistant	encounter	127	99.00	16.63	**209088.99**	
Physical Therapy Total:						**165870.00**
Physical Therapy	encounter	57	75.00	22.17	**94776.75**	
Physical Therapy Assistant	encounter	57	75.00	16.63	**71093.25**	
Speech Therapy Total:						**737928.45**
Speech Therapy	encounter	317	105.00	22.17	**737928.45**	
Community Day Supports Total:						**30360997.84**
Community Day Supports	1 hour	2937	466.49	22.16	**30360997.84**	
Financial Management Services Total:						**4950000.00**
Financial Management Services	per month	4500	11.00	100.00	**4950000.00**	
Goods and Services Total:						
			GRAND TOTAL:			**400420941.67**
			Total Estimated Unduplicated Participants:			**10500**
			Factor D (Divide total by number of participants):			**38135.33**
			Average Length of Stay on the Waiver:			365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						524246.52
Goods and Services	Per Item	571	7.00	131.16	524246.52	
Home and Community Services Total:						41102433.90
Home and Community Services	1 hour	2937	466.49	30.00	41102433.90	
Support Broker Total:						13117500.00
Support Broker	monthly	4500	11.00	265.00	13117500.00	
Attendant Care Total:						3549.60
Attendant Care	15 Minutes	3	408.00	2.90	3549.60	
Behavioral Supports Total:						33587820.00
Behavioral Supports	15 Minutes	2806	360.00	33.25	33587820.00	
Environmental and Minor Home Adaptations Total:						5000.00
Environmental and Minor Home Adaptations	15 Minutes	10	1.00	500.00	5000.00	
				GRAND TOTAL:		400420941.67
				Total Estimated Unduplicated Participants:		10500
				Factor D (Divide total by number of participants):		38135.33
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2727615.00
Adult Day Health	15 Minutes	271	3660.00	2.75	2727615.00	
Adult Day Training Total:						19115068.50
Adult Day Training	15 Minutes	1926	3609.00	2.75	19115068.50	
Case Management Total:						19602000.00
Case Management	Monthly	5500	11.00	324.00	19602000.00	
Community Living Supports Total:						22060390.80
Community Living Supports					22060390.80	
				GRAND TOTAL:		362476875.92
				Total Estimated Unduplicated Participants:		10500
				Factor D (Divide total by number of participants):		34521.61
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minutes	1995	1996.00	5.54		
Homemaker Total:						**329829.50**
Homemaker	15 Minutes	77	659.00	6.50	**329829.50**	
Personal Care Total:						**201280863.60**
Personal Care	15 Minutes	7785	6337.00	4.08	**201280863.60**	
Respite Total:						**9940875.00**
Respite	15 minutes	5250	541.00	3.50	**9940875.00**	
Supported Employment Total:						**321120.56**
Supported Employment	15 Minutes	337	172.00	5.54	**321120.56**	
Occupational Therapy Total:						**487832.40**
Occupational Therapy	encounter	127	99.00	22.17	**278743.41**	
Occupational Therapy Assistant	encounter	127	99.00	16.63	**209088.99**	
Physical Therapy Total:						**165870.00**
Physical Therapy	encounter	57	75.00	22.17	**94776.75**	
Physical Therapy Assistant	encounter	57	75.00	16.63	**71093.25**	
Speech Therapy Total:						**737928.45**
Speech Therapy	encounter	317	105.00	22.17	**737928.45**	
Community Day Supports Total:						**15755932.99**
Community Day Supports	1 hour	2937	466.49	11.50	**15755933.00**	
Financial Management Services Total:						**5500000.00**
Financial Management Services	per month	5000	11.00	100.00	**5500000.00**	
Goods and Services Total:						**524246.52**
Goods and Services	Per Item	571	7.00	131.16	**524246.52**	
Home and Community Services Total:						**15755932.99**
Home and Community Services	1 hour	2937	466.49	11.50	**15755933.00**	
Support Broker Total:						**14575000.00**
Support Broker	monthly	5000	11.00	265.00	**14575000.00**	
Attendant Care Total:						**3549.60**
Attendant Care	15 Minutes				**3549.60**	
			GRAND TOTAL:			**362476875.92**
			Total Estimated Unduplicated Participants:			**10500**
			Factor D (Divide total by number of participants):			**34521.61**
			Average Length of Stay on the Waiver:			365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		3	408.00	2.90		
Behavioral Supports Total:						**33587820.00**
Behavioral Supports	15 Minutes	2806	360.00	33.25	**33587820.00**	
Environmental and Minor Home Adaptations Total:						**5000.00**
Environmental and Minor Home Adaptations	15 Minutes	10	1.00	500.00	**5000.00**	
				GRAND TOTAL:		**362476875.92**
				Total Estimated Unduplicated Participants:		**10500**
				Factor D (Divide total by number of participants):		**34521.61**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**2727615.00**
Adult Day Health	15 Minutes	271	3660.00	2.75	**2727615.00**	
Adult Day Training Total:						**19115068.50**
Adult Day Training	15 Minutes	1926	3609.00	2.75	**19115068.50**	
Case Management Total:						**19602000.00**
Case Management	Monthly	5500	11.00	324.00	**19602000.00**	
Community Living Supports Total:						**22060390.80**
Community Living Supports	15 Minutes	1995	1996.00	5.54	**22060390.80**	
Homemaker Total:						**329829.50**
Homemaker	15 Minutes	77	659.00	6.50	**329829.50**	
Personal Care Total:						**201280863.60**
Personal Care	15 Minutes	7785	6337.00	4.08	**201280863.60**	
Respite Total:						**9940875.00**
Respite	15 minutes	5250	541.00	3.50	**9940875.00**	
Supported Employment Total:						
				GRAND TOTAL:		**362476875.92**
				Total Estimated Unduplicated Participants:		**10500**
				Factor D (Divide total by number of participants):		**34521.61**
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						321120.56
Supported Employment	15 Minutes	337	172.00	5.54	321120.56	
Occupational Therapy Total:						487832.40
Occupational Therapy	encounter	127	99.00	22.17	278743.41	
Occupational Therapy Assistant	encounter	127	99.00	16.63	209088.99	
Physical Therapy Total:						165870.00
Physical Therapy	encounter	57	75.00	22.17	94776.75	
Physical Therapy Assistant	encounter	57	75.00	16.63	71093.25	
Speech Therapy Total:						737928.45
Speech Therapy	encounter	317	105.00	22.17	737928.45	
Community Day Supports Total:						15755932.99
Community Day Supports	1 hour	2937	466.49	11.50	15755933.00	
Financial Management Services Total:						5500000.00
Financial Management Services	per month	5000	11.00	100.00	5500000.00	
Goods and Services Total:						524246.52
Goods and Services	Per Item	571	7.00	131.16	524246.52	
Home and Community Services Total:						15755932.99
Home and Community Services	1 hour	2937	466.49	11.50	15755933.00	
Support Broker Total:						14575000.00
Support Broker	monthly	5000	11.00	265.00	14575000.00	
Attendant Care Total:						3549.60
Attendant Care	15 Minutes	3	408.00	2.90	3549.60	
Behavioral Supports Total:						33587820.00
Behavioral Supports	15 Minutes	2806	360.00	33.25	33587820.00	
Environmental and Minor Home Adaptations Total:						5000.00
Environmental and Minor Home Adaptations	15 Minutes	10	1.00	500.00	5000.00	
				GRAND TOTAL:		362476875.92
				Total Estimated Unduplicated Participants:		10500
				Factor D (Divide total by number of participants):		34521.61
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**2727615.00**
Adult Day Health	15 Minutes	271	3660.00	2.75	**2727615.00**	
Adult Day Training Total:						**19115068.50**
Adult Day Training	15 Minutes	1926	3609.00	2.75	**19115068.50**	
Case Management Total:						**19602000.00**
Case Management	Monthly	5500	11.00	324.00	**19602000.00**	
Community Living Supports Total:						**22060390.80**
Community Living Supports	15 Minutes	1995	1996.00	5.54	**22060390.80**	
Homemaker Total:						**329829.50**
Homemaker	15 Minutes	77	659.00	6.50	**329829.50**	
Personal Care Total:						**201280863.60**
Personal Care	15 Minutes	7785	6337.00	4.08	**201280863.60**	
Respite Total:						**9940875.00**
Respite	15 minutes	5250	541.00	3.50	**9940875.00**	
Supported Employment Total:						**321120.56**
Supported Employment	15 Minutes	337	172.00	5.54	**321120.56**	
Occupational Therapy Total:						**487832.40**
Occupational Therapy	encounter	127	99.00	22.17	**278743.41**	
Occupational Therapy Assistant	encounter	127	99.00	16.63	**209088.99**	
Physical Therapy Total:						**165870.00**
Physical Therapy	encounter	57	75.00	22.17	**94776.75**	
Physical Therapy Assistant	encounter	57	75.00	16.63	**71093.25**	
Speech Therapy Total:						**737928.45**
Speech Therapy	encounter	317	105.00	22.17	**737928.45**	
Community Day Supports Total:						
			GRAND TOTAL:			**362476875.92**
			Total Estimated Unduplicated Participants:			**10500**
			Factor D (Divide total by number of participants):			**34521.61**
			Average Length of Stay on the Waiver:			366

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						15755932.99
Community Day Supports	1 hour	2937	466.49	11.50	15755933.00	
Financial Management Services Total:						5500000.00
Financial Management Services	per month	5000	11.00	100.00	5500000.00	
Goods and Services Total:						524246.52
Goods and Services	Per Item	571	7.00	131.16	524246.52	
Home and Community Services Total:						15755932.99
Home and Community Services	1 hour	2937	466.49	11.50	15755933.00	
Support Broker Total:						14575000.00
Support Broker	monthly	5000	11.00	265.00	14575000.00	
Attendant Care Total:						3549.60
Attendant Care	15 Minutes	3	408.00	2.90	3549.60	
Behavioral Supports Total:						33587820.00
Behavioral Supports	15 Minutes	2806	360.00	33.25	33587820.00	
Environmental and Minor Home Adaptations Total:						5000.00
Environmental and Minor Home Adaptations	15 Minutes	10	1.00	500.00	5000.00	
				GRAND TOTAL:		362476875.92
				Total Estimated Unduplicated Participants:		10500
				Factor D (Divide total by number of participants):		34521.61
				Average Length of Stay on the Waiver:		366

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2727615.00
Adult Day Health	15 Minutes	271	3660.00	2.75	2727615.00	
Adult Day Training Total:						19115068.50
Adult Day Training					19115068.50	
				GRAND TOTAL:		380296875.92
				Total Estimated Unduplicated Participants:		10500
				Factor D (Divide total by number of participants):		36218.75
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 Minutes	1926	3609.00	2.75		
Case Management Total:						**37422000.00**
Case Management	Monthly	10500	11.00	324.00	**37422000.00**	
Community Living Supports Total:						**22060390.80**
Community Living Supports	15 Minutes	1995	1996.00	5.54	**22060390.80**	
Homemaker Total:						**329829.50**
Homemaker	15 Minutes	77	659.00	6.50	**329829.50**	
Personal Care Total:						**201280863.60**
Personal Care	15 Minutes	7785	6337.00	4.08	**201280863.60**	
Respite Total:						**9940875.00**
Respite	15 minutes	5250	541.00	3.50	**9940875.00**	
Supported Employment Total:						**321120.56**
Supported Employment	encounter	337	172.00	5.54	**321120.56**	
Occupational Therapy Total:						**487832.40**
Occupational Therapy	encounter	127	99.00	22.17	**278743.41**	
Occupational Therapy Assistant	encounter	127	99.00	16.63	**209088.99**	
Physical Therapy Total:						**165870.00**
Physical Therapy	encounter	57	75.00	22.17	**94776.75**	
Physical Therapy Assistant	encounter	57	75.00	16.63	**71093.25**	
Speech Therapy Total:						**737928.45**
Speech Therapy	encounter	317	105.00	22.17	**737928.45**	
Community Day Supports Total:						**15755932.99**
Community Day Supports	1 hour	2937	466.49	11.50	**15755933.00**	
Financial Management Services Total:						**5500000.00**
Financial Management Services	per month	5000	11.00	100.00	**5500000.00**	
Goods and Services Total:						**524246.52**
Goods and Services	Per Item	571	7.00	131.16	**524246.52**	
Home and Community Services Total:						**15755932.99**
Home and Community Services	1 hour				**15755933.00**	
			GRAND TOTAL:			**380296875.92**
			Total Estimated Unduplicated Participants:			**10500**
			Factor D (Divide total by number of participants):			**36218.75**
			Average Length of Stay on the Waiver:			365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		2937	466.49	11.50		
Support Broker Total:						**14575000.00**
Support Broker	monthly	5000	11.00	265.00	**14575000.00**	
Attendant Care Total:						**3549.60**
Attendant Care	15 Minutes	3	408.00	2.90	**3549.60**	
Behavioral Supports Total:						**33587820.00**
Behavioral Supports	15 Minutes	2806	360.00	33.25	**33587820.00**	
Environmental and Minor Home Adaptations Total:						**5000.00**
Environmental and Minor Home Adaptations	15 Minutes	10	1.00	500.00	**5000.00**	
				GRAND TOTAL:		**380296875.92**
				Total Estimated Unduplicated Participants:		**10500**
				Factor D (Divide total by number of participants):		**36218.75**
				Average Length of Stay on the Waiver:		365